STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150160	A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA ORTHOPAEDIC HOSPITAL LLC	8400 NORTHWEST BLVD INDIANAPOLIS, IN46278

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S0000	This visit was for a standard licensure survey. Facility Number: 003930 Survey Date: 8-8/10-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 08/22/11	S0000		
S0178	410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation, the hospital failed	S0178	The license at the Greenwood	08/15/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	to conspicuously post the hospital license in an area open to patients and the public in 1 instance. Findings: 1. On 8-8-11 at 10:45 am in the presence of employee #A3, it was observed in the Greenwood offsite that the hospital's license was not posted conspicuously in an area open to patients and the public.		offsite was moved to an area that is more open to patients. The was completed on 8/15/2011 by Annette Nelson and confirmed by Jane Keller on 8/20/2011	
S0312	410 IAC 15-1.4-1(c)(6)(D) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the facility failed to conduct, per facility policy, a performance evaluation for 5 of 11 employee files reviewed. Findings: 1. Review of 15 personnel files indicated	S0312	Effectively immediately, an authorized hospital employee will review all performance evaluations conducted by the contracted company. The director of HR will be responsible for making sure that this occurs and random audits will be conducted to make sure that this is occurring as per policy.	09/12/2011

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	contracted employee files PF#10, PF#11, PF#12, PF#13, PF#14, and PF#15 did not contain any documentation of performance evaluation by the facility itself nor any documentation of review by an authorized hospital employee of the evaluation conducted by the contractor. 2. On 8-8-11 at hospital staff was requested to provide the above documentation and none was provided prior to exit. 3. On 8-10-11 at 11:55 am, upon interview, employee #A1 was requested to provide documentation of the facility's policy on performance evaluation. The employee indicated the policy was as indicated in the employee handbook. 4. Review of a section in the handbook entitled PERFORMANCE EVALUATION, indicated performance evaluations are generally performed on an annual basis.			

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S0318	410 IAC 15-1.4-1(c)(6)(F) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.			
	Based on document review and interview, the hospital failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for health care workers, who provide direct patient care in 1 of 6 files reviewed. Findings: 1. Review of 6 employee files of health care workers who provide direct patient care indicated file PF#10, a contracted ultrasonographer, did not have any documentation of CPR competency. 2. On 8-8-11 at 3;30 pm, employee #A6 was requested to provide the above documentation and none was provided prior to exit.	S0318	Beginning immediately, all health care workers, including contracted and agency personnel will have proof of CPR competence in their employee files. If this is not obtained in a timely manner, then the employee will not be scheduled to work until proof is available. The director of HR will make sure this is accomplished and the safety manager will conduct random audits to make sure facility is in compliance.	09/12/2011

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S0330	410 IAC 15-1.4-1(c)(6)(K) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable. Based on document review and interview, for 11 employee files reviewed, the hospital failed to maintain personnel files for 3 employees for immunizations, 2 for Hepatitis B status and 3 employees for tuberculin tests. Findings: 1. Review of hospital PolicyStat ID: 77017, entitled Employee Vaccination, indicated all employees who do not have documentation of Rubella vaccine or do not have laboratory evidence of immunity must be vaccinated. Further review indicated all employees who do not have a reliable history of Varicella disease or	S0330	Beginning immediately we will begin the process of getting all documentation into the personnel files so they include documentation of proper immunizations, TB tests and Hep B status. The director of HR will be responsible for making sure that this is completed. The safety manager will conduct random audits to make sure facility is in compliance.	10/10/2011

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	proof of vaccination must have a Varicella titer. Those who are seronegative for Varicella must be vaccinated. 2. Review of 11 personnel files indicated files PF#7, PF#8 and PF#10 did not have any documentation of immunization history to Rubella and Varicella. 3. Review of hospital PolicyStat ID: 77017, entitled Employee Vaccination, indicated employees with the potential for occupational exposure to Hepatitis B on the average of one or more times per monthly and who do not have documentation or history of completion of the vaccine series or laboratory evidence of prior disease, should obtain this vaccine. Further review indicated personnel who were offered the Hepatitis B vaccine and decline have documentation entered into their record indicating their choice. 4. Review of 11 personnel files indicates files PF#10 and PF#11, both had the potential for occupational exposure to Hepatitis B on the average of one or more times per monthly. They both also did not have documentation or history of completion of the vaccine series or laboratory evidence of prior disease. Further review indicated these 2 personnel had no documentation of declining to be			

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	offered the Hepatitis B vaccine. 5. Review of hospital PolicyStat ID: 77017, entitled Employee Vaccination, indicated all employees are required to have a TB [tuberculosis] screening within six (6) months of employment and annually thereafter. 6. Review of 11 personnel files indicated files PF#1, PF#10 and PF#11 did not have any documentation of a current annual TB screening. 7. For all the above files lacking documentation, on 8-8-11 at 3:30 pm, employee #A6 and on 8-10-11 at 3:15 pm, employee # A1 were requested to provide the above documentation and none was provided prior to exit.			
S1020	410 IAC 15-1.5-7 (d)(2)(A) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (A) Separation of drugs designed for external use from drugs intended for internal use. Based on document review and interview,	S1020	Effectively immediately, the physical therapy departments will	09/12/2011

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	the hospital failed to ensure the monthly inspection of 3 areas where drugs are stored. Findings: 1. Review of hospital PolicyStat ID: 7492, entitled Quality Control - Drug Storage Areas - Monthly Inspections, indicated all medication storage areas shall be inspected by personnel familiar with proper storage requirements at least every month, inspections shall be documented and the pharmacist manager is responsible for reviewing the inspection reports. 2. On 8-9-11 at 10:10 am in the presence of employees #A4 and #A5, upon interview, employee #A7, indicated 3 Physical Therapy treatment areas were stocked with the medication dexamethasone. This employee was asked to provide documentation of monthly pharmacy checks in those areas. Upon interview, the employee indicated there was no documentation and none was provided prior to exit.		conduct monthly pharmacy checks and submit those checks to the pharmacy manager for review. The director of physical therapy will be responsible for enforcing this policy and the pharmacy manager will be responsible for the review.	

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S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, the facility failed to ensure no condition was created or maintained which may result in a hazard to patients, public, or employees in one (1) instance. Findings: 2. On 8-9-11 at 10:30 am in the presence of employees #A4 and #A5, it was observed in the Clean Supply Room in the Radiology area, there was an alcohol-based hand sanitizer (ABHS) affixed to a wall directly above an electrical outlet. 3. The location of the ABHS, being located directly over an electrical ignition source, posed a fire hazard if the flammable alcohol was sprayed or dropped into the ignition source.	S1118	The ABHS was moved to a new location on the wall so that it is not above the electrical receptacle. This was completed by the facility manager and confirmed by the safety manager.	08/15/2011

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S1150	410 IAC 15-1.5-8 (c)(9) (c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following: (9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department.			
	Based on observation, the hospital failed to a install backflow prevention device as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance. Findings: 1. On 8-9-11 at 10:50 am in the presence of employees #A4 and #A5, it was observed in an Environmental Services closet there was a flexible hose connected to a water spigot and there was no backflow preventor.	S1150	A vacuum breaker type backflow prevention device was installed on the spigot in this area. This work was completed by the facility manager and confirmed by the safety manager.	08/15/2011

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S1160	410 IAC 15-1.5-8(d)(1) (d) The equipment requirements are as follows: (1) All equipment shall be in good working order and regularly serviced and maintained. Based on document review, the facility failed to follow the manufacturer's recommendation for weekly maintenance of 1 defibrillator. Findings: 1. Review of the ZOLL R Series Operator's Guide indicated there was a document entitled Operator's Checklist for R Series Product. This document indicated recommended checks and procedures to be performed weekly. They included, but were not limited to checking, the overall condition of the defibrillator, Hands-free Therapy electrodes, Paddles, Inspect cables for cracks, broken wires, connector, Batteries Fully charged spare battery available, and checking Disposable supplies. 2. Review of hospital PolicyStat ID: 85122, entitled Daily Checklist-Crash Cart And Critical Equipment, indicated the contents of the crash cart and the functioning of critical equipment shall be checked each day of operation. The	S1160	Effectively immediately all departments will follow the manufacturer's recommendation for weekly maintenance of the defibrillator. The facility checklist will be revised to encompass all aspects as listed by the manufacturer. The education coordinator will be responsible for completing this task and the safety manager will do random audits to ensure compliance.	09/12/2011

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	policy further indicated to record results of inspection on checklist (attached). 3. Review of a document entitled CRASH CART CHECK LOG for August, 2011, provided by employee #A4, indicated it did not document the above weekly checks as indicated in the Operator's Checklist for R Series Product. 4. On 8-10-11 am, employee #A4 was requested to provide documentation of weekly checks and no other documentation was provided prior to exit.			
S1164	410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on interview, the hospital failed to provide evidence of preventive maintenance (PM) for 1 piece of	S1164	Effective immediately, all equipment will have PM's on them. The unit in question, the Sonoline G-4, has had the PM	09/12/2011

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	equipment Findings: 1. On 8-9-11 at 10:20 am, hospital staff was requested to provide documentation of PM on a piece of ultrasound equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was provided prior to exit.		completed on it and this particular piece of equipment has been added to our equipment list so that it is not overlooked in the future. The manager of materials will be responsible for compliance and the safety manager will conduct random audits to make sure equipment is not overlooked.	